_____ County Food Stamp Program

Notification of EBT System Transaction Error

Name: _____

Address:_____

_____

Case ID#: _____ **FSIS ID#:** _____

It has been determined that extra food stamp benefits were placed in your EBT account in error. You received $ _____ in error due to a system malfunction. This transaction occurred at _____ on _____. Benefits in the amount of $_____ will be taken out of your EBT account on _____, which is ten workdays from the date of this letter. Additional information concerning this transaction is attached.

The State regulations supporting this action are found in Section 920, EBT System Transaction Error Adjustments, of the Food Stamp Certification Manual.

You have a right to a fair hearing of your case if you do not agree with our decision. You can get a fair hearing by letting your local Food Stamp Office or County Department of Social Services know you want a hearing. You may contact them either in person, by telephone, or in writing. The hearing may be requested by any member of your household or by your authorized representative. You can be represented at the hearing by a personal representative, including an attorney obtained at your own expense. Free legal advice may be available; contact your nearest Legal Services Office for more information.

You have 90 days from the date of this letter, that is, until _____ to request a hearing. If you do not ask for a hearing by this date, you can not have one.

If you disagree with the decision to deduct the food stamp benefits from your account and request a hearing within ten calendar days, benefits will not be taken out of your account until a hearing decision is reached. Once the extra benefits are deducted from the EBT account, no adjustment will be made until a hearing decision is reached. If the hearing finds that our decision was correct, the benefits will be deducted from your EBT account.

To request a hearing, call your local Food Stamp Office at _____ or fill out and return the form below. If you want to discuss our decision or ask any questions about how a fair hearing works, call your local Food Stamp Office.

Caseworker: _____ **Date:** _____

If you want a fair hearing, fill out this form, tear off, and mail to: _____ **County DSS**

Address: _____

_____

_____

Name of Person Requesting Hearing: _____ Today's Date: _____

Address: _____

Phone Number: _____ Signature: _____

Why do you want a fair hearing? _____

_____

FOR OFFICE USE ONLY:

Caseworker: _____ **Date Notice Mailed to Client:** _____

Date Hearing Request **Received:** _____ **Date DSS-1473 Mailed:** _____

Figure 920-1